

**Case Summary.** When devices (balloon, stent etc) are changed or manipulated in complex lesion, it cannot be emphasized enough that guidewire keeping is very important.

However, if the pull-out of guidewire unexpectedly happen in the dissected lesion during PCI for heavy calcific, and angulated lesion, CTO devices such as Corsair and CTO guidewires can be useful.

#### TCTAP C-128

#### Successful Rescue of Life Threatening Coronary Perforation

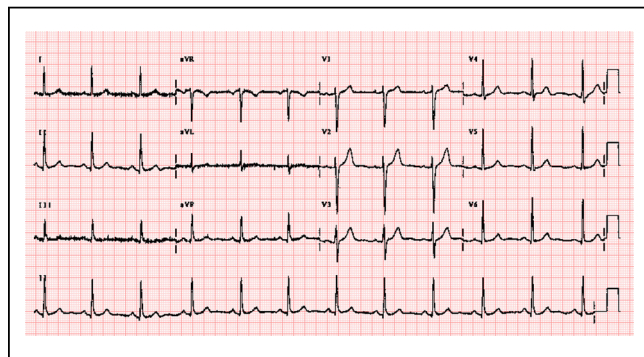
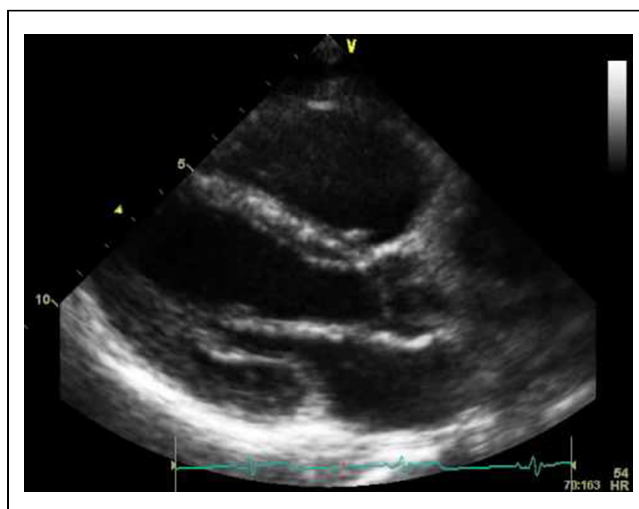
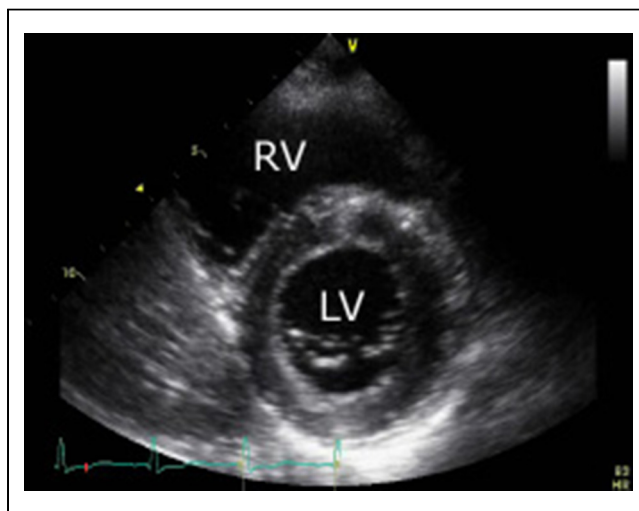
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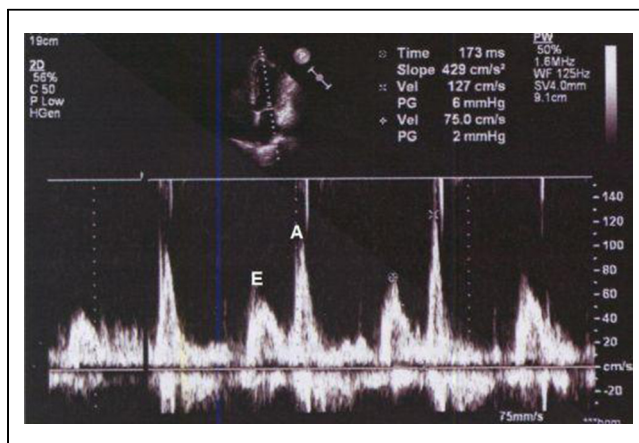
#### [CLINICAL INFORMATION]

Patient initials or identifier number. PIC

**Relevant clinical history and physical exam.** 71 year old male, non-DM, non-HTN presenting with class II symptoms of Dyspnea and angina for last one year and progressed to NYHA class-III since three years months. His P- 78/ min. BP - 140/90 and Cardiovascular Examination was normal. Chest X-ray was normal with a cardiothoracic ratio pf 0.5. Resting ECG s/o no significant ST-T changes.



**Relevant test results prior to catheterization.** Echocardiography shows Valves were structurally normal, no Regional wall motion abnormality, preserved left ventricular systolic function (EF- 60%) and evidence of diastolic dysfunction, No significant PH.



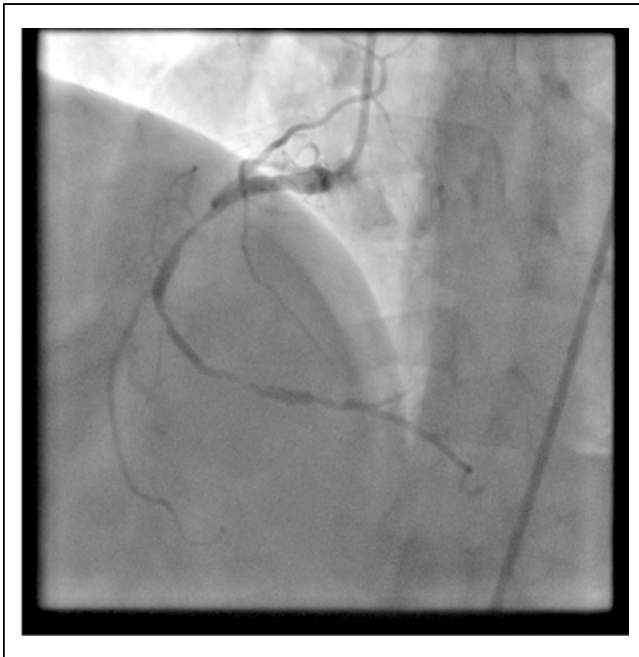
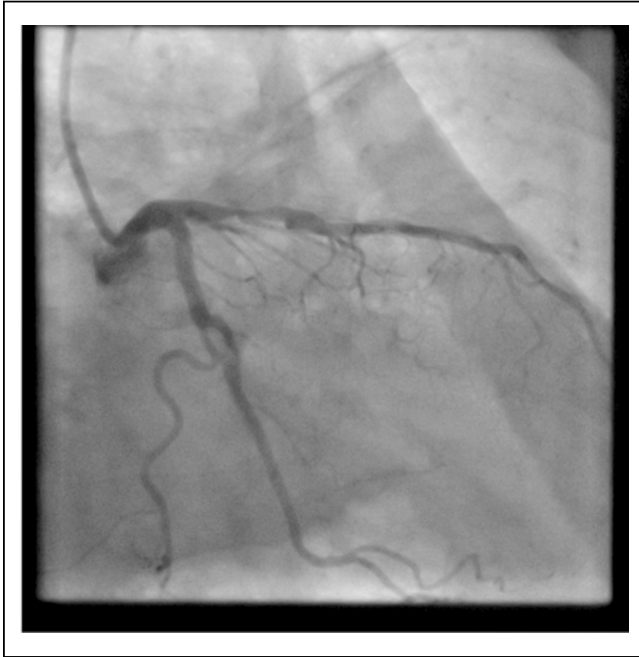
**Relevant catheterization findings.** Coronary angiogram:

Left Main: Normal

LAD: Proximal 80% stenosis, 50% mid segment lesion.

LCx: Non-dominant, Normal. OM1: proximal 70% stenosis.

RCA: Dominant, Proximal 70-80 % stenosis and two tandem lesions of 70% mid and distal segment.



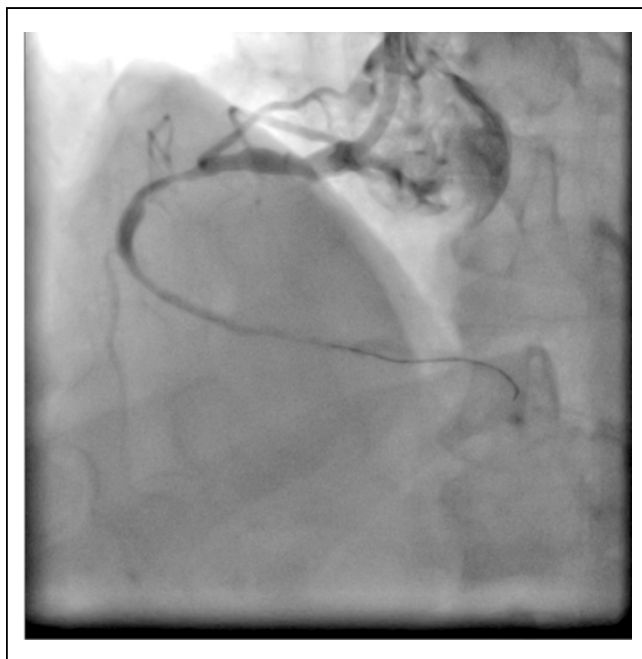
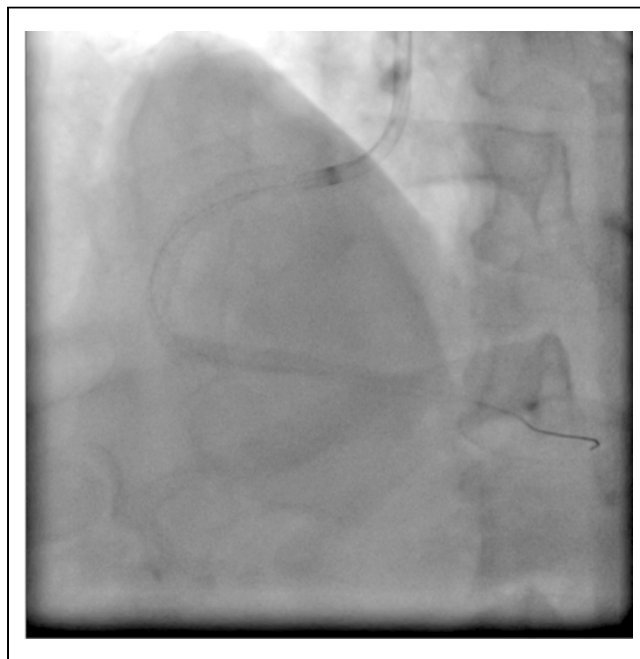
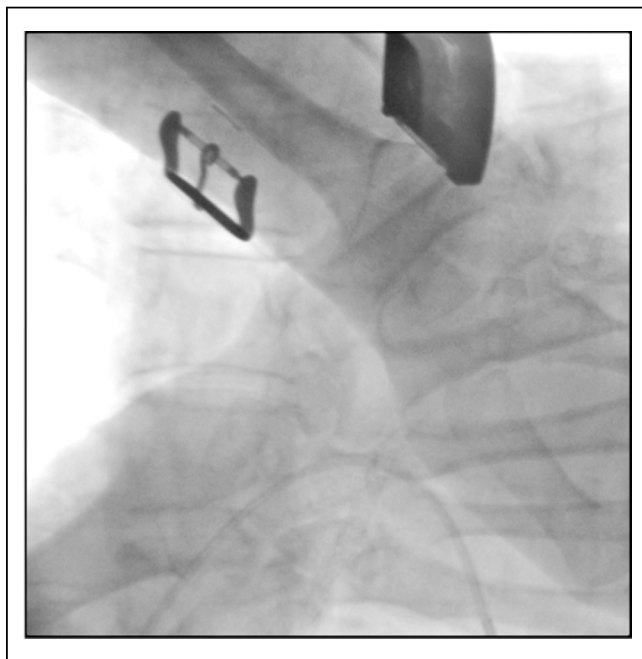
#### [INTERVENTIONAL MANAGEMENT]

**Procedural step.** PTCA to LAD: 7F EBU 3.5 cm guide catheter to left coronary ostium and LAD lesion was crossed with BMW guidewire. The lesion was predilated with 3\*12 Sprinter balloon and was stented with 3.5\*16 Promus Element. Check Angio revealed excellent results with TIMI III flow.

PTCA to RCA: 7F JR 4 SH guide catheter to right coronary ostium and RCA lesion was attempted to cross with Fielder FC guidewire with micro support. Due to complexities of the lesion multiple wires were taken (Whisper MS, Pilot 150) and then the lesion was successfully crossed. In view of dissection noted in the distal RCA, the distal, mid and proximal RCA was stented with 2.25\*24 Resolute, 2.5\*28 Biomatrix, 3.25\*24 Biomatrix stents respectively. Check angio revealed excellent result of stenting although a Type III perforation was noted in distal PLV. In view of its contained nature with hemodynamic stability the patient was observed on cath table and was subsequently shifted to recovery.

After 15 mins in the recovery the patient was found unresponsive and pulse less. CPR was started and patient was taken on cath table and a 2D echo revealed cardiac tamponade.

The patient was shifted to the cath table where check angio showed a grade III perforation which was attempted to seal off with balloon dilatation (2\*12 Sprinter- 6Atm, 15 minutes). After failure to do so, 2 cc cyanoacrylate glue was selectively injected in the PLV through micro-catheter and check angio showed sealed off perforation and patient improved hemodynamically.



**Case Summary.** Coronary perforation is a rare complication of percutaneous coronary intervention and management requires early detection and angiographic classification. Caution is needed while advancing guide wires and dilating the coronary lesion either pre-stent, during or post-stent implantation. Distal coronary artery perforations need use of various embolic materials, which an interventional cardiologist should be aware and have experience in using them.

#### TCTAP C-129

#### Percutaneous Coronary Intervention in Patient with Unstable Angina and Abdominal Aortic Aneurysm Supported by 6-French Intra-Aortic Balloon Pumping via Brachial Artery Using 6-French Slender Sheath

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#### [CLINICAL INFORMATION]

**Patient initials or identifier number.** 90085

**Relevant clinical history and physical exam.** A 73-year-old man with worsening chest pain at rest was admitted to our hospital. He had history of inferior wall old myocardial infarction and severely reduced renal function. His chest pain at rest was uncontrollable with optimal medical therapy, and percutaneous coronary intervention was performed.

**Relevant test results prior to catheterization.** His electrocardiogram showed abnormal Q-wave in inferior leads, and his echocardiography revealed reduced ejection fraction of 43%, with severe hypokinesis of infero-posterior wall. He also had an infra-renal abdominal aortic aneurysm of 50 mm in diameter.

**Relevant catheterization findings.** He underwent coronary angiography, which showed severe stenosis in the proximal part of the left anterior descending artery and chronic total occlusion in the proximal part of the right coronary artery.

#### [INTERVENTIONAL MANAGEMENT]

**Procedural step.** A 6-French guiding catheter was inserted through the right brachial artery and a floppy guidewire was advanced into the left anterior descending artery. After pre-dilatation with a 2.5 / 15 mm balloon catheter, the coronary flow deteriorated because of a distal embolism, and his hemodynamic condition severely deteriorated.

A 6-French Glidesheath Slender (Terumo, Tokyo, Japan), which has thinner wall and outer diameter is equal to conventional 5-French sheath, was inserted through the left brachial artery. A pigtail catheter was advanced into the descending aorta using 0.035 inch guidewire, and the guidewire was exchanged to the guidewire dedicated to the